About hearsay - or reappraisal of the role of the anamnesis as an instrument of meaningful communication

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As a result of the ICT revolution and enhancement of diagnostic possibilities, the anamnesis, as an instrument of meaningful communication in disease and a cornerstone of medical practice throughout the ages, has lost in importance. Nowadays, we are on the brink of a more patient-tailored and individualised therapy, so there is a growing need for an open dialogue in the doctor-patient relationship, a situation very similar to the beginning of the professionalisation of assistance in disease in ancient medicine. Reappraisal of the anamnesis and awareness of the patient-doctor relationship are therefore warranted and for that reason its roots and evolution are discussed from a historic perspective. (*Neth Heart J* 2007;15: 359-62.)

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Living in a land of milk and honey, we are inclined to take our health and healthcare system for granted. We have become used to an ever-increasing life expectancy where illness and disease are limited to the last decade of life. At that time, we heavily rely on technical achievements to alleviate the burden of old age, when skilful doctors plug in and play with sophisticated tools, perhaps curing but not necessarily caring at the same time.

Of course, an exaggeration like this is not meant to conceal the very blessings that the ICT revolution and evidence-based medicine have brought to us but, on the other hand, it is well known that for some patients these remain blessings in disguise, especially when they do not fit in the selected group under study. In other words, because our individual DNA structure is unique, reactions to biomedical processes are rather variable, sometimes leading to unexpected consequences. The effect of β-blockers, for instance, is dependant on the genetic profile of the patient involved, urging tailored or personalised medicine instead of the group-wise approach we are used to.[1]

Figure 1. The doctor and his patient in an informative and persuasive dialogue.

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Figure 2. A day at the forum: meet and greet in an informal way of interrelation.

In our ever-changing society, our patient care is increasingly being characterised by jurisdiction and efficiency. New referral strategies, for instance, are being developed and diagnostic procedures are performed in advance to facilitate patient turnover. In dedicated outpatient clinics, the concept of 'conveyer-belt care' has been developed.

But what about dialogue and the case history, the old cornerstones in medical practice? It is reassuring to think that queries from patients and information folders take care of everything. Problems arise when evidence-based medicine touches the very boundaries of the essence of human existence, using a purely technical solution to shift these boundaries, as is the case in the MADIT study, where a lot of effort was put into the cost-effectiveness discussion[2] rather than the psychological consequences of being internally defibrillated on a regular basis.

Dialogue is essential for a well-considered decision on an individual basis, although some would prefer a 'safety belt' approach at all times and any cost. Literally being on speaking terms is mandatory and perhaps a lesson or two can be learned from ancient times.

Hodie (to-day), or wishful thinking in an unmanageable daily practice

Along with the progress in disease management and technical achievements in the last decades, the anamnesis, literally meaning reminiscence, has increasingly become an interview, strictly guided by the interviewer. The doctor-patient relationship was already subject to debate in the fifth century BC, when one view was that a physician, being the only person possessing scientific knowledge, acts merely by conveying instructions to his patients, and this role model has undoubtedly dominated the history of Western medicine up until this very day.[3]

Then there are those who think that a modern lifestyle also means that regular check-ups are mandatory. Bare measurements are used as a substitute for a proper anamnesis and are intended to provide confidence and a feeling of health, although the person may not necessarily feel well. Ingredients like these, together with an overwhelming technology with many diagnostic and therapeutic tools, has resulted in a steadily declining significance of the anamnesis itself.

In the stone age of cardiology, the 1950s, the importance of a proper anamnesis and physical examination were still vigorously underlined and stood beyond all doubt.[4] A proper anamnesis is a comprehensive and time-consuming exercise, having regard for a number of aspects, such as recording the facts, separating the chaff from the wheat by limiting data, interrupting and asking for details when necessary and avoiding suggestive questions to fill in a presumptive diagnosis.

Time is not on our side and therefore general principles, although firmly established, are increasingly being violated, sometimes stimulated by hospital managers constantly searching for better control of the processes involved. So physicians, feeling the pressure, will carry on relying on their routine and specific symptoms beside all sorts of diagnostic procedures in order to meet contemporary demands not only of the patients involved but also of the guidelines imposed in a society that is becoming more and more juridical. Nevertheless, in recent textbooks, too, the importance of the anamnesis is stressed without verbiage but then again the emphasis is laid on the interpretation of specific symptoms.[5]

Heri (yesterday), or mutual benefit in an open compassionate dialogue with our patients

Herodotos (484 to 425 BC), the oldest known Greek historian, mentioned in his *Historiae, Liber I, cap. 197-198* the Babylonian custom of carrying the ill and needy to the marketplace so passers-by could speak with them, interviewing them and learning about the patient's condition so that they could provide good advice and urge the patient to take a medication that had been proven effective in comparable circumstances. Nobody was allowed to give a sick person the cold shoulder. In a sense, although there were no official doctors involved, one could say that this practice was a first attempt to deal with disease in a more or less organised manner. From this customary solidarity in the earliest sense a more professional doctor-patient relationship arose, which remained a very public affair for a long time.

Greek doctors in the fourth and fifth century BC were already aware of the importance of their relationship with the sick. In contrast with the view mentioned before, where the doctor dominates the scenery, the notion of a genuine Hippocratic spirit which propagated the idea that the doctor should carry on a continuous informative and persuasive dialogue with his patient met with approval and gradually this attitude gained ground.

In those days, medical practice was very much a public affair where the reputation of the doctor was initially measured against his ability to observe rather than interrogate. It took a while before a systematic form of questioning was on firm ground. Therefore, there is more to it than just an interest in looking for genuine thoughts and advice in antiquity, as was noted down in the Corpus Hippocraticum, a compilation of writings mainly produced in the period from 430 to 350 BC.

Rufus Ephesius lived in Rome at the end of the first century AD. His writings were very detached and eclectic with a preference for the anatomy he had learned in Alexandria. Among other works, he composed a manual on how to take the anamnesis, still readable and to the point in our modern times. He was convinced that questioning a patient is a prerogative for a correct diagnosis and prognosis.[6] In his *Opera,* general rules were set which still stand in a time

when health issues and lifestyle are increasingly becoming part of the public domain once more.

'*Patients should be questioned in order to learn about the nature of their disease, to facilitate the negotiation that follows. Interrogation of the patient is a priority to ensure whether he is mentally ill or not and to establish his strength or weakness. Bystanders could be of use if the patient is not able to convey the information asked. One should reckon with possible obstacles like madness, apoplexy, unconsciousness, exaltation, speechlessness, stupor, complete exhaustion or imposed silence, for instance in pulmonary bleeding.*

Time of onset of the affliction involved is of major importance for specific treatment and in recognition of critical days or moments. Periodicity is then uncovered which is meaningful because the same symptoms, manifesting at different moments of time, could bare a different meaning, as is the case in the onset of icterus, nose bleeding and the aspect of excrement.

In order to get a hold on the clinical course hitherto one should form an idea of regularity, irregularity and evolvement of symptoms, whether the onset is acute or intense, or if the outbreak of disease is sudden and rapid or slow and gradual.

Obviously knowledge about prevalence is important simply because of the fact that when many more people are suffering from the same symptoms, the patient is more determined in demanding the same treatment. Learn from every patient about his diet and drinking habits and/or if he is taking any medication. Appetite and thirst, for instance, are markers of a lifestyle which admit a correct prognosis regarding discernment, loquacity, cheerfulness, disposition and peace of mind.

A doctor is able to uncover many aspects of the disease involved by observation alone but he will be much better informed by interrogation. A certain diagnosis is dependant on the nature of the aetiology. When someone for instance is trembling from cold or fear it is less imminent then trembling from an internal disease. When someone is struck by insanity, recovery will be more rapid when it is caused by drunkenness or intoxication rather than other causes of mental disorder.

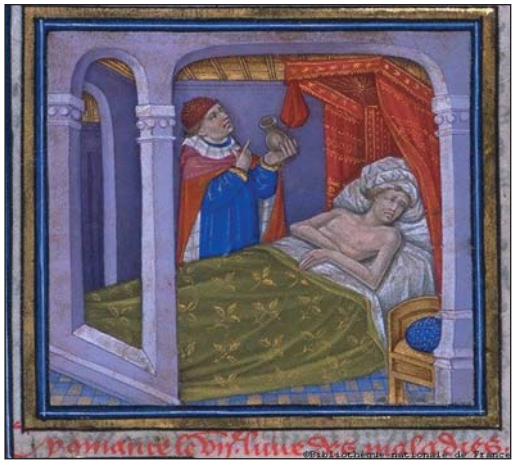

Figure 3. Doctor and patient in medieval times; the remedy is worse than the disease.

One should ask about the nature of pain, although it is possible to reach a fair judgement looking at the moaning and groaning, the restlessness, timidity, attitude, colour, weakness and the movements of the hands. Nevertheless, it is necessary to discriminate true pain from lamentation and therefore interrogation is mandatory for a proper diagnosis. For it is known that many of the patients, driven from weakness or timidity, pretend to suffer from pains that are no less simulated than the pains displayed in drama. Because most pains tend to be episodic one should make inquiries about this aspect too. Finally it is recommended that relatives and bystanders are asked for their opinion of the diseased for a broader perspective.'

Discussion

In the early days of civilisation the basis for dealing with disease was rooted in a genuine and firm belief in human solidarity. With the professionalisation of assistance came regulation and a notion of a scientific process, while looking at each other's work and commenting upon its content.

At first sight similarities in the doctor-patient relationship, bridging 2.5 thousand years of medical practice, are of interest but then it is the differences that really count. Striking similarities, nowadays very much in focus again, are surprisingly enough patient behaviour – patients have a ready tongue and negotiate their treatment – and the importance ascribed to basic lifestyle characteristics, including intoxications and the fear of loss of reputation of the doctor involved. ('After all, it is a free market.')

Perhaps more important are recognisable differences in reason and attitude. In stressing the importance of a meaningful conversation with a patient, Rufus Ephesius adheres to the followers of Hippocrates whereas in modern Western medicine the doctor seems omniscient and reluctant to accept contradiction.

Reviewing the medical literature on this topic, however, a systematic discussion on the value of the anamnesis as a cornerstone in medical examination has failed to appear for a very long time.

Our dedication to rationalisation in human affairs arose in the 17th century with Galileo and Descartes as exponents of the revolutionary intellectual changes in those days. At that time Europe set out on a journey that led to a number of technical achievements, especially in the field of medicine but also to a deeply felt human failure in ignoring the tolerance and sepsis of the 16th century humanists. The knowledge of those humanists may not be lost in order to develop a conception where the abstract rigor and exactness of the 17th century's 'new philosophy' is combined with a practical interest in human life and its concrete details for the benefit of a balanced human development.[7] Of course the way to encounter disease and patients was subject to this development too and therefore the anamnesis as a most individual expression of illness has become more and more standardised to meet the demands of ICT and the electronic patient file, as long-term products of the 17th century way of thinking in physics and philosophy.

For now and to meet efficiency standards, a directive approach dominates the doctor-patient relation in medical

Figure 4. Reminiscence Archeologique de l' Angelus by Salvador Dali.

practice. Strange enough, however, it is the ongoing research and discovery of our heaven (the genetic code) that made us realise that a more individual approach in disease is preferable. In a way, ongoing knowledge thus guaranties some sort of reappraisal of 16th century humanistic values and in doing so of the basic rules of taking an anamnesis too, set in antiquity as pointed out by Rufus Ephesius.

Conclusion

Looking into the future we can still learn a lesson or two from ancient medicine. Of course one can persistently argue for the proven superiority of high-tech and ICT-derived medicine as a spin-off of 17th century revolutionary thinking, but then again only the human standard makes it all worthwhile and this very fact simply cannot be ignored, as for example is demonstrated in a discussion in this Journal about the need for implantation of ICDs in larger groups of patients.[8] Looking at present circumstances and developments, is it really farfetched to assume that in the present doctor-patient relationship, more or less automatically the first impression (cynically enough in evolution a tool meant for survival) is gaining weight to an extent that there is a clear danger of loss of objectivity at first sight? At least we should be aware of this possibility in an ever more market-driven environment. Therefore, let us not throw out the baby with the bathwater by ignoring the very fundamentals on which medical professionalism was built: conscious attention for a meaningful communication with our patients, to give the Hippocratic Oath a second life. In a doctor-patient relationship for some it may seem that silence is golden as long as doctor's eyes can see, but then we had better stick to the wisdom of Socrates for whom asking questions was essential in helping to reach the true answer. ■

References

1 DeGeorge BR, Koch WJ. Beta Blocker specificity: a building block toward personalized medicine. *J Clin Invest* 2007;**117**:86-9.
2 Mushlin AI, Hall WJ, Zwanziger J, Gajary E, Andrews M, Marron R, et al. The cost-effectiveness of automatic implantable cardiac defibrillators: results from MADIT Multicenter Automatic Defibrillator Trial. *Circulation* 1998;**97**:2129-35.
3 Jori A. The doctor and his relationship with patients in Greece in the fifth and fourth centuries BC. *Med Secoli* 1997;**9**:189-221.
4 Formijne P. Leerboek der anamnese en der fysische diagnostiek. Scheltema & Holkema, Amsterdam. 1968.
5 Hovingh GK, Somsen GA. Probleemgeorienteerd denken in de cardiologie, een praktijkboek voor de opleiding en de kliniek. De Tijdstroom, Utrecht. 2007
6 Haak HL, Horstmanshoff HFJ. The anamnesis in antiquity; medical questions by Rufus Ephesius (1st to 2nd century AD). *Ned Tijdschr Geneeskd* 2006;**150**:2825-9.
7 Toulmin S, Cosmopolis; the hidden agenda of modernity. The Free Press, New York. 1990
8 Ramdat Misier AR, de Boer MJ, Beukema WP. Selection of patients for ICD therapy still under debate. *Neth Heart J* 2006;**14**:421-2.